U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 03 February 2003

Case No: 2002-BLA-0306

In the Matter of

CONLEY LEE DANIELS,
Claimant

v.

LEECO, INC.,
Employer,

TRANSCO ENERGY COMPANY,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Edmund Collett, Esquire
For the claimant

Lois A. Kitts, Esquire
For the employer/carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER — DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the Act). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2001).

On April 30, 2002, this case was referred to the Office of Administrative Law Judges for a formal hearing. (DX 108). Following proper notice to all parties, a hearing was held on October 2, 2002 in Hazard, Kentucky. The Director's exhibits were admitted into evidence pursuant to 20 C.F.R. § 725.456, and the parties had full opportunity to submit additional evidence. The record was kept open until November 18, 2002. (Tr. 6).

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, CX, and EX refer to the exhibits of the Director, claimant, and employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

The following issues remain for resolution:

1. whether the claim was timely filed;

2. the length of the miner's coal mine employment;

3. whether the miner has pneumoconiosis as defined by the Act and regulations;

4. whether the miner's pneumoconiosis arose out of coal mine employment;

5. whether the miner is totally disabled;

6. whether the miner's disability is due to pneumoconiosis;

7. the number of the miner's dependents for purposes of augmentation of benefits; and

8. whether the evidence establishes a change in conditions or a mistake in a determination of fact within the meaning of Section 725.310.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

The claimant, Conley Lee Daniels, was born on May 24, 1934. (DX 1). Mr. Conley married Loretta Whitaker on May 20, 1952, and they reside together in Bonnyman, Kentucky. (Tr. 9). On his application for benefits, claimant alleged that he has one dependent child, Amanda Daniels. (DX 1). Claimant did not finish the third grade in school. (Tr. 10-11).

Claimant's testimony concerning his smoking history is contradictory, and I do not credit it. At the beginning of his testimony, he alleges to have started smoking around age 25 and stopping ten years ago, around the age of 58. (Tr. 11). Claimant's testimony, thus, would produce a 33 year smoking history, consisting of approximately one pack of cigarettes per day. *Id.* Later, however, Claimant alleges to have smoked only slightly over one decade. (Tr. 27). When questioned about the inconsistency, Mr. Daniels became agitated and confrontational, reducing his credibility on the issue. Furthermore, the figures reported by Claimant to the various physicians examining him for his claim have varied greatly. Given the Claimant's original admission of over thirty years of smoking and the frequency with which physicians attributed an approximately thirty year smoking history to him, I find that the evidence reveals Claimant to possess at least a thirty year smoking history.

Beyond his smoking, Claimant suffers from other ailments. Before he finished his coal mine employment, he was already experiencing breathing difficulties. (Tr. 18). Since that time, he testified that his problems have progressed. *Id.* Claimant coughs and smothers at night, causing him to sleep upright and wake up three to four times per night. (Tr. 19). Claimant also stated that he had injured his back before leaving his last coal mine employer. (Tr. 26).

Because of his breathing and coughing, Claimant testified that he does not get out much. He cannot climb steps without tiring, and he testified that he could not return to coal mine employment because of his breathing difficulties. (Tr. 23). He also stated that he had problems with his nerves. (Tr. 22). Claimant's testimony regarding his physical limitations, however, is undercut by admissions he made under cross-examination. Claimant alleged to have quit hunting and fishing in eight years earlier, but he admitted that he continued to get his hunting and fishing license every year. (Tr. 33-34). He stated that he purchased the license and would go hunting or

fishing "if [he] felt like it." (Tr. 34). Then, Claimant admitted that it had only been five or six years since he had been hunting. *Id.* Given the inconsistency in his testimony on the topic of his physical abilities and the frequency of purchasing a license for an activity one claims not to have done in many years, I grant less weight to Claimant's testimony concerning his physical abilities.

The instant case possesses a tangled procedural history. Mr. Daniels filed his original application for black lung benefits on April 15, 1993. (DX 1). The Office of Workers' Compensation Programs denied the claim on September 22, 1993. (DX 16). Claimant appealed, and a formal hearing occurred on December 7, 1994. (DX 17, 28). The administrative law judge denied benefits on February 21, 1995, and Claimant appealed to the Benefits Review Board. (DX 29, 30). On July 28, 1995, the Benefits Review Board issued a decision, affirming the administrative law judge's denial of benefits. (DX 35).

Subsequently, Claimant submitted additional evidence, and the Office of Workers' Compensation Programs accepted the evidence as a request for modification. (DX 36-38). After the submission of additional evidence, (DX 39-41, 43-45), the Office of Workers' Compensation Programs denied the claim again on July 5, 1995. (DX 46). Four days after the denial, Claimant requested a formal hearing. (DX 47). Further medical evidence was then submitted, (DX 49-51), and the Office of Workers' Compensation Programs issued another denial on October 29, 1996. (DX 52). Pursuant to Claimant's November 1, 1996 hearing request, the case was transferred to the Office of Administrative Law Judges on February 3, 1997. (DX 53, 55). On May 27, 1998, an administrative law judge issued a decision on the record, denying modification. (DX 62). Claimant appealed to the Benefits Review Board, and the Board subsequently affirmed the administrative law judge's denial in a June 1, 1999 opinion. (DX 67).

On December 9, 1999, Claimant again requested modification of his claim and submitted new medical evidence. (DX 69). On February 22, 2000, the district director issued a Proposed Decision and Order Denying Request for Modification. (DX 75). Claimant requested a formal hearing on February 24, 2000, and he subsequently submitted additional evidence. (DX 76-77). Claimant's request for modification was denied on September 15, 2000.[1] Claimant again requested modification on May 15, 2001. (DX 89, 91-92).[2] On December 20, 2001, the district director issued another Proposed Decision and Order Denying Modification. (DX 105). The district director determined that the evidence was adequate to demonstrate pneumoconiosis; however, he also determined that the evidence did not demonstrate that Claimant suffered from

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[1] The instant case file was reconstructed, and the Court has not been provided an actual copy of the denial. (DX 99). The date of the denial has been taken from later correspondence between the relevant parties included in the file.

[2] The Court assumes an error is contained in the Office of Workers' Compensation Programs correspondence with Claimant. (DX 92). The denial occurred on September 15, 2000, and not September 15, 2001. Were the latter date correct, the claimant's request for modification would have preceded the denial.

total disability due to pneumoconiosis. *Id.* On January 3, 2002, Claimant requested a formal hearing, and the case was transferred to the Office of Administrative Law Judges on April 30, 2002. (DX 106, 108).

Timeliness

Under Section 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. Because the record contains no evidence that claimant received the requisite notice more than three years prior to filing his claim for benefits, I find that this claim was timely filed.

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. Claimant bears the burden of proof in establishing the length of his coal mine work. *See Shelesky v. Director, OWCP*, 7 B.L.R. 1-34, 1-36 (1984); *Rennie v. U.S. Steel Corp.*, 1 B.L.R. 1-859, 1-862 (1978). The evidence in the record includes a Social Security Statement of Earnings encompassing the years 1950 to 1992, employment history forms, applications for benefits, and claimant's testimony. (DX 1-7). The length of a miner's coal mine work history must be computed as provided by 20 C.F.R. § 725.l01(a)(32). *See* 20 C.F.R. § 718.301.

On his application for benefits, Claimant alleged nineteen years of coal mine employment. (DX 1). His employment history form alleges the following coal mine employment. (DX 2).

Coal Mine Employer	Dates of Employment
1. London Clements	1950 to 1952
2. Blue Diamond Coal Co.	1952 to 1957
3. River Processing	1981 to 1990
4. Leeco Coal Co.	1990 to 1993

Id. The Claimant's testimony corroborates his alleged coal mine employer and dates of employment. (Tr. 11-18). Furthermore, the Social Security records support Claimant's allegations of coal mine employment with Blue Diamond Coal Company, River Processing, and Leeco Coal

Company. (DX 3).[3] The provisions of 20 C.F.R. § 725.101(a)(32)(ii) provide that the dates and length of employment may be established by any credible evidence including, but not limited to, company records, pension records, earnings statements, coworker affidavits, and sworn testimony. Given the consistency between Claimant's testimony, written allegations, and the Social Security records, I credit Claimant with nineteen years of coal mine employment. I find his testimony and written allegations, as corroborated by the Social Security records, sufficiently demonstrate the beginning and ending dates of his coal mine employment. While the Social Security records do not reflect his employment from 1950 to 1952, neither do they present evidence contradicting it. I also acknowledge that many coal mine employers from that time period did not report all of their employees, if any, to the federal government.

Claimant's last coal mine employer was Leeco, Inc. (Tr. 17; DX 2-3). Claimant worked for Leeco for approximately three years, during which time he worked on the belt line and shoveled dust form the air locks. (Tr. 17-18). His job was completely composed of manual labor, and he was constantly exposed to dust. *Id.* Claimant's testimony and written submission confirm that his usual coal mine employment required moderately heavy manual labor.

Medical Evidence

Medical evidence submitted under a claim for benefits under the Act must be in "substantial compliance" with the applicable regulations' criteria for the development of medical evidence. *See* 20 C.F.R. §718.101 to 718.107. The regulations address the criteria for chest x-rays, pulmonary function tests, physician reports, arterial blood gas studies, autopsies, biopsies, and "other medical evidence." *Id.* "Substantial compliance" with the applicable regulations entitles medical evidence to probative weight as valid evidence.

Because the instant claim is for modification, I shall separately catalog the evidence received in the record since the previous denial on September 15, 2000.[4] I will review the new evidence alone to determine if Claimant has demonstrated a change in conditions. I shall review the entire record, however, to determine if a mistake of fact has been made in a prior determination.

[3] The Social Security records reflect several different coal mine employers from 1981 to 1990. (DX 3). Claimant testified that River Processing changed names several times during this period. (Tr. 16).

[4] *See supra* notes 1-2.

Evidence Submitted Since Previous Denial

A. X-ray reports[5]

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 103	11/06/95	11/07/95	Pampati	COPD is noted. No evidence of pleural effusion.
n/a	06/16/99	n/a	Rosenberg	Negative. Interstitial linear changes in right mid-lung field laterally; basilar linear changes also seen.
CX 1	02/03/00	11/10/02	Alexander/B/BCR	2/1 pneumoconiosis
DX 98	09/15/01	09/15/01	Baker	1/0 pneumoconiosis
DX 104	09/15/01	12/02/01	Barrett/B/BCR	½ pneumoconiosis
CX 2	11/09/01	11/10/02	Alexander/B/BCR	2/1 pneumoconiosis

[5] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. §718.102(a,b). It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease.

B. Pulmonary Function Studies[6]

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Tracings	Comments
DX 98 09/15/01	Baker	67 67’	2.33	3.05	71	0.76	Yes	Within normal limits
n/a 11/09/01	Rosenberg	67 68’	2.26 2.38*	2.79 3.00*	70 39*	0.81 0.79*	Yes	Good cooperation and fair effort. Moderate restrictive defect present.

*denotes testing after administration of bronchodilator

C. Arterial Blood Gas Studies[7]

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX 103	11/06/95	Yalamanchi	36.4	79.0	Resting	
n/a	11/09/01	Rosenberg	40.3	75.8	Resting	

[6] The pulmonary function study, also referred to as a ventilatory study or spirometry, indicates the presence or absence of a respiratory or pulmonary impairment. 20 C.F.R. § 718.104(c) . The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Board has held that a ventilatory study which is accompanied by only two tracings is in “substantial compliance” with the quality standards at § 718.204(c)(1). *Defore v. Alabama By-Products Corp.*, 12 B.L.R. 1-27 (1988). The values from the FEV1 as well as the MVV or FVC must be in the record, and the highest values from the trials are used to determine the level of the miner's disability.

[7] Blood-gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. 20 C.F.R. §718.105(a).

D. Narrative Medical Evidence

On June 28, 2000, Dr. George Chaney issued a brief, general letter. (DX 103). In his letter, Dr. Chaney states, "This patient has been seen by me and I reviewed his x-rays and his laboratory studies and I believe that he has coal worker's [sic] pneumoconiosis. I have also reviewed Dr. Dahhan's work-up and Dr. Dahhan also believes that this patient suffers from coal worker's [sic] pneumoconiosis." *Id.*

Dr. Glen Baker examined Claimant on September 15, 2001. (DX 98). Claimant presented the doctor with over eighteen years of coal mine employment and an eight to ten year, one pack of cigarettes per day smoking history. Claimant informed Dr. Baker that he quit smoking six to seven years earlier. During the examination, Claimant's chief complaints were shortness of breath, cough, sputum production, and wheezing. Claimant also described sleeping trouble and dyspnea upon exertion such as walking fifty feet on level ground. In addition to his physical examination, Dr. Baker administered a chest x-ray, pulmonary function test, and an arterial blood gas study. Dr. Baker recorded that 1) he interpreted the chest x-ray as category 1/0; 2) the pulmonary function test results were normal; and 3) the arterial blood gas study results revealed mild resting arterial hypoxemia. The doctor diagnosed coal workers' pneumoconiosis based upon Claimant's x-ray and history of dust exposure, mild resting arterial hypoxemia based upon Claimant's arterial blood gas study results, and chronic bronchitis based upon Claimant's history. Further addressing his pneumoconiosis diagnosis, Dr. Baker explained that Claimant had no other conditions to account for Claimant's x-ray changes. Dr. Baker opined that Claimant was totally disabled from work in the coal mining industry or other dusty occupations due to the fact that he had developed pneumoconiosis. The doctor states, "Patient has only an 8-10 pack year history of smoking and 18.5 years of coal dust exposure with x-ray evidence of pneumoconiosis. It is thought that any pulmonary impairment would be caused at least in part by his coal dust exposure." *Id.*

Dr. David M. Rosenberg issued an opinion on a prescription notepad on November 9, 2001. (DX 100). The doctor commented that Claimant's x-ray raised the possibility that Claimant suffered from a hernia.

Dr. Rosenberg issued an examination report and independent medical review on September 13, 2002. Dr. Rosenberg examined Claimant on November 9, 2001, and he reviewed numerous pieces of medical evidence generated by other physicians. A substantial portion of the doctor's report is his recitation of the findings and reports of other physicians. During his examination of Claimant, Dr. Rosenberg reported that Claimant's chief complaints were cough, sputum production, wheeze, shortness of breath, and dyspnea upon exertion such as walking one block or climbing one flight of stairs. The doctor recorded Claimant's medical and social histories, noting that Claimant possessed an approximately thirty-five year, one pack per day smoking history ending in 1995. Claimant presented the doctor with an eighteen and one-half year underground coal mine employment history as a belt line operator and miner helper. In addition to his physical

examination, Dr. Rosenberg administered an electrocardiogram, chest x-ray, arterial blood gas study, and a pulmonary function test. The doctor stated the following results: 1) the electro-cardiogram results were normal; 2) the chest x-ray revealed interstitial changes in the mid and lower lung zones with a profusion of 1/1; 3) the arterial blood gas study was normal; and 4) the pulmonary function test results, produced with fair effort, evidenced a mild restriction. After his examination and review, the doctor opined that Claimant did not suffer from pneumoconiosis. Dr. Rosenberg explained that his diagnosis was based upon the following criteria: 1) his examination observations that Claimant had clear lung fields; 2) the arterial blood gas study results indicating a normal diffusing capacity; and 3) the x-ray films produced during his examination and the examinations of other physicians producing only linear opacities. The doctor also opined that Claimant was not totally disabled. He did conclude that Claimant suffered from a mild impairment. Dr. Rosenberg stated that Claimant was not totally disabled based upon the facts that 1) Claimant's mild restriction was associated with a normal diffusing capacity measurement and 2) his oxygenation was generally preserved. The doctor stated that Claimant could perform, from a pulmonary standpoint, his previous coal mine employment or other similarly arduous types of activity.

Dr. Matthew Vuskovich issued an independent medical review on September 25, 2002. (EX 3). Dr. Vuskovich reviewed numerous pieces of medical evidence, including ten examination reports, forty-three x-ray interpretations, ten pulmonary function test results, seven arterial blood gas study results, one independent medical review, one deposition, and miscellaneous correspondence. In his report, the doctor stated that Claimant possessed a twenty year under-ground coal mine employment history and a thirty year, one-half pack of cigarettes per day smoking history. Addressing the medical reports he reviewed, Dr. Vuskovich opined that the physical examination findings in 1993 and 1998 were consistent with an infectious process, and he noted that x-ray evaluations revealed some residual scarring, apparently due to a pulmonary infection. Specifically focusing on the numerous x-ray interpretations he reviewed, the doctor commented that the preponderance of the x-ray evidence indicated "the absence of x-ray changes that are [] consistent with the typical x-ray changes associated with the pneumoconioses." *Id.* Concerning Claimant's pulmonary function test results, Dr. Vuskovich noted that Claimant produced invalid results due to his inability to exert sufficient effort caused by his Bell's palsy. Dr. Vuskovich, however, also noted that Claimant produced normal values in 2001. The doctor stated that the arterial blood gas study results were normal. In his analysis section, the doctor admitted that Claimant's coal mine employment history placed him at an increased risk for developing an occupational pulmonary disease. The doctor, however, also commented that "Cigarette smoking for at least thirty years represented a major confounding independent non-work-related cause of pulmonary disease." *Id.* The doctor remarked that there was no x-ray evidence of coal workers' pneumoconiosis, nor was there evidence of chronic obstructive pulmonary disease. The doctor also concluded that Claimant suffered from no pulmonary impairment and retained the pulmonary capacity to work in the coal industry. Dr. Vuskovich opined that, if Claimant had any physical impairments, they were not related to his pulmonary system. He based his opinion on the normal and stable condition of Claimant's "bellows," "conduit" and "gas exchange" functions of his thorax and lungs.

The deposition of Dr. Rosenberg was taken on October 30, 2002. The doctor's deposition testimony primarily reiterates his written findings. His testimony, however, explicitly includes his opinion that the pulmonary impairment suffered by the claimant relates to his "long smoking history." (Rosenberg Depo., p. 13).

The deposition of Dr. Jerome F. Wiot, board-certified radiologist, was taken on November 7, 2002. (EX 4). In his testimony, the doctor reviewed his findings of the eight x-ray films he reviewed.

E. Miscellaneous Medical Evidence

The record also contains various medical records from Appalachian Regional Healthcare Hospital. (DX 103). Most of the documents do not address Claimant's pulmonary condition or impairment level, although one document, entitled "Vitals Problems Procedures & DX" lists "COPD" and "CWP" under "Other Problems."

In an undated, brief narrative, Dr. R. V. Mettu produced an opinion attached to Claimant's November 9, 2001 pulmonary function test. The doctor stated that the spirometry revealed a moderate restrictive airway disease. He opined that the lung volumes were consistent with a restrictive airway disease.

Previously Submitted Evidence

A. X-ray reports

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 78	04/02/81	06/14/81	Greene/B	Completely negative
DX 78	04/04/84	08/15/84	Ellingson/B	Completely negative
DX 80	04/10/87	03/14/00	Wiot/B/BCR	Completely negative
DX 81	04/10/87	03/25/00	Spitz/B/BCR	Completely negative
DX 79	01/21/93	01/30/93	Anderson	1/1 pneumoconiosis
DX 25	01/21/93	09/20/93	Wells	2/1 pneumoconiosis
DX 15	05/11/93	05/11/93	Wicker	Negative.
DX 13, 14	05/11/93	05/25/93 09/28/93	Sargent/B/BCR	0/1 profusion. Negative. Smoking history? Film quality = 3.

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 25	08/10/93	08/10/93	Clarke	2/1 pneumoconiosis
DX 26	08/10/93	03/17/94	Wright	Negative
DX 26	08/10/93	04/13/94	Powell/B/BCR	Negative
DX 26	11/30/93	11/30/93	Broudy/B	Negative
DX 80	11/30/93	03/14/00	Wiot/B/BCR	Negative
DX 81	11/30/93	03/25/00	Spitz/B/BCR	Negative
DX 36	03/20/95	03/20/95	Sundaram	1/1 pneumoconiosis
DX 43	03/20/95	03/21/95	Reddy/BCR	1/1 pneumoconiosis
DX 44	03/20/95	04/23/96	Sargent/B/BCR	Negative
DX 45	03/20/95	05/04/98	Barrett/B/BCR	1/1 pneumoconiosis
DX 39	07/17/95	12/12/95	Bassali/B/BCR	1/1 pneumoconiosis
DX 40	07/17/95	01/03/96	Sargent/B/BCR	Negative
DX 41	07/17/95	01/29/96	Poulos/B/BCR	Completely negative
DX 36	08/29/95	09/19/95	Bassali/B/BCR	1/1 pneumoconiosis
DX 37	08/29/95	10/11/95	Sargent/B/BCR	Negative
DX 53	09/20/96	10/28/96	Poulos/B/BCR	Film unreadable.
DX 51	10/15/96	10/15/96	Broudy	Negative. 0/1 profusion.
DX 80	10/15/96	03/14/00	Wiot/B/BCR	Negative
DX 81	10/15/96	03/25/00	Spitz/B/BCR	Negative
DX 80	06/09/98	03/14/00	Wiot/B/BCR	Negative
DX 81	06/09/98	03/25/00	Spitz/B/BCR	Negative
DX 69	06/16/99	06/16/99	Chaney	1/1 pneumoconiosis
DX 81	06/16/99	04/07/00	Wiot/B/BCR	Negative
DX 82	06/16/99	04/27/00	Spitz/B/BCR	Negative
DX 78	06/16/99	03/14/00	Wheeler	Negative

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 78	06/16/99	03/14/00	Scott	Negative
DX 86	06/16/99	07/25/00	Rosenberg	Negative
DX 77	02/03/00	02/03/00	Dahhan	1/1 pneumoconiosis
DX 80	02/03/00	04/12/00	Wheeler	Negative. Film underexposed. Film quality = 3
DX 80	02/03/00	04/12/00	Scott	Negative. Film underexposed. Film quality = 2.
DX 82	02/03/00	05/05/00	Spitz/B/BCR	Negative
DX 74	02/04/00	02/04/00	Broudy	Negative
DX 80	02/04/00	03/14/00	Wiot/B/BCR	Negative
DX 81	02/04/00	03/25/00	Spitz/B/BCR	Negative
DX 80	02/04/00	04/05/00	Scott	Negative
DX 80	02/04/00	04/05/00	Wheeler	Negative
DX 83	06/05/00	06/05/00	Baker/B	1/0 pneumoconiosis

B. Pulmonary Function Studies

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Tracings	Comments
DX 10 05/11/93	Wicker	59 68’	2.01 1.95*	2.36 2.71*	68 56*		Yes	Fair comprehension, good cooperation. Effort fair at best, thus it is not felt to represent a valid study.
DX 25 07/01/93	Wells	59 68’	1.78 1.03*	1.78	12.2 27.3*		Yes	
DX 25 08/10/93	Clarke	59 68’	2.40	2.60			Yes	Good cooperation

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Tracings	Comments
DX 26 11/30/93	Broudy	59 67’	2.74	3.37	44		Yes	Poor cooperation
DX 36 03/20/95	Sundaram	61 68’	2.10	2.87	84.0	0.73	Yes	Mild restriction
DX 51 10/15/96	Broudy	62 67’	2.43	3.70	44.00	0.66	Yes	Less than optimal effort. Slight abnormality with mild obstruction.
DX 72 02/03/00	Dahhan	65 67’	2.37	3.12	46.00	0.75	Yes	Fair cooperation, good comprehension
DX 74 02/04/00	Broudy	65 67’	2.52 2.52*	3.18 3.25*	64 62*	0.79 0.77*	Yes	Good cooperation, fairly good effort. Very mild restrictive defect
DX 69 06/15/99	Chaney	65 68’	2.46	3.2	60.3	0.77	Yes	Mild restriction

*denotes testing after administration of bronchodilator

Validation Studies: Dr. Maan Younes, board-certified in pulmonary medicine, issued a validation opinion on August 26, 1996 addressing Claimant’s July 1, 1993 pulmonary function test. (DX 49). Dr. Younes opined that the test results were invalid due to an insufficient number of trials.

C. Arterial Blood Gas Studies

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX 12	05/11/93	Wicker	39.6 42.1	85.4 85.5	Resting Exercise	
DX 26	11/30/94	Broudy	37.2	82.2	Resting	
CX 2	11/16/95	Goli	36.4	79.0		
DX 51	10/15/96	Broudy	38.3	92.6	Resting	Normal
DX 74	02/04/00	Broudy	36.0	83.7	Resting	Normal

D. Narrative Medical Evidence[8]

Dr. Mitchell Wicker examined Claimant on May 11, 1993. (DX 11). Dr. Wicker recorded Claimant's medical, social, and familial histories, and he reviewed Claimant's coal mine employment history form. The doctor noted an approximately thirty year, one-half pack per day smoking history. During the examination, Claimant's chief complaints were cough, sputum production, wheezing, dyspnea upon exertion such as walking one to one and one-half blocks, chest pain, and ankle edema. He submitted Claimant to a physical examination, pulmonary function test, chest x-ray, arterial blood gas study, and an electrocardiogram. Dr. Wicker opined that Claimant did not suffer from pneumoconiosis. Furthermore, he concluded that Claimant's pulmonary condition could not be assessed due to the claimant's failure to comply with the pulmonary function studies.

Dr. Gregory Wells examined Claimant on July 1, 1993. (DX 25). The doctor recorded that Claimant possessed a twenty-eight year, less than one pack per day smoking history and a nineteen year coal mine employment history. Claimant reported the following symptoms: smothering, coughing, shortness of breath when lying down, orthopnea, and dyspnea upon walking one hundred yards. In addition to his physical examination, Dr. Wells administered a pulmonary function test. The doctor opined that Claimant suffered from pneumoconiosis based upon an x-ray interpretation of 1/0. Dr. Wells also concluded that Claimant was physically unable, from a pulmonary standpoint, to perform his usual coal mine employment or comparable employment. The doctor based his impairment assessment on Claimant's pulmonary function test results, and he attributed Claimant's impairment to nineteen years of coal mine employment and twenty-eight years of smoking.

On August 10, 1993, Dr. W. F. Clarke examined Claimant. (DX 25). Claimant presented the doctor with an eighteen year coal mine employment history as a belt line operator, rock duster, and repairman. Claimant also alleged a twenty year, one pack per day smoking history. Claimant's chief complaints were shortness of breath and dyspnea upon exertion such that Claimant can no longer walk or bend over and dig because of his shortness of breath. Dr. Clarke administered a chest x-ray and a pulmonary function test in addition to his physical examination. He diagnosed coal workers' pneumoconiosis based upon the following factors: 1) his interpretation of Claimant's x-ray, 2) Claimant's history of coal dust exposure, and 3) the doctor's experience treating miners with pneumoconiosis. Dr. Clarke also opined that Claimant was totally and permanently disabled. Dr. Clarke stated that Claimant's pneumoconiosis was the etiology of Claimant's disability, and that he could locate no other significant etiology for the disability.

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[8] Dr. Rosenberg issued an independent medical review on July 25, 2000. (DX 86). I will not consider the report, however, as it is duplicative. In the doctor's September 13, 2002 independent medical review, Dr. Rosenberg specifically listed his July 25, 2000 report as one piece of evidence he reviewed. Accordingly, the doctor is commenting on the same evidence in his September 2002 report as he was in his July 2000 report.

Dr. Bruce Broudy, board-certified in internal medicine and pulmonary medicine, examined Claimant on November 30, 1993. (DX 26, 51, 74). He recorded Claimant's social and medical histories, noting a twenty-seven year, one-half pack of cigarettes per day smoking history and a twenty-two year coal mine employment history as a general laborer and belt line operator. Claimant's chief complaints were shortness of breath, back pain, cough, wheezing, and chest pain. Beyond his examination, Dr. Broudy administered a pulmonary function test, arterial blood gas study, and a chest x-ray. The doctor recorded that the pulmonary function test results were normal except for a reduced MVV value due to poor effort and the arterial blood gas study results were normal except for an elevated carboxyhemoglobin level suggesting continued exposure to smoke. The doctor interpreted Claimant's chest x-ray as negative for coal workers' pneumoconiosis. He diagnosed dyspnea and chest pain. He also opined that Claimant retained the pulmonary capability of performing his usual coal mine work or similarly arduous labor.

Dr. Broudy's deposition testimony was taken on December 30, 1993. (DX 26). The doctor reiterated his written findings and testified that Claimant possessed a substantial smoking history. The doctor explained that the results of Claimant's pulmonary function test and arterial blood gas study suggest that Claimant's dyspnea "might be nonpulmonary in origin." (DX 26, p. 13).

On March 20, 1995, Dr. Raghu Sundaram examined Claimant. (DX 36). Claimant presented Dr. Sundaram with a sixteen year coal mine employment history and a thirty year, one-half pack of cigarettes per day smoking history. Claimant's chief complaints during the examination were 1) a shortness of breath upon walking one-half block or climbing three to five stairs, 2) an inability to bend, crawl, or stoop, and 3) back pain. The doctor administered a chest x-ray, pulmonary function test, and arterial blood gas study in addition to his physical examination. Dr. Sundaram diagnosed coal workers' pneumoconiosis due to prolonged exposure to coal dust, and he concluded that Claimant was unable, from a pulmonary standpoint, to perform his usual coal mine employment or comparable employment due to Claimant's shortness of breath with limited activity. The doctor based his impairment analysis on Claimant's pulmonary function test results, and he attributed Claimant's impairment to prolonged exposure to coal dust.

Dr. George Chaney reviewed a CT scan of Claimant's chest on January 24, 1996. (DX 103). His only comment was that Claimant's chest was "negative for any mass." *Id.*

On November 2, 1995, Dr. Chaney examined Claimant. (DX 69). In his brief examination report, Dr. Chaney stated that Claimant's lung fields were clear with decreased breath sounds. He did not offer any diagnosis concerning the presence or absence of pneumoconiosis. Dr. Chaney offered identical chest analyses on January 22, 1996, February 6, 1996, October 10, 1996, December 28, 1996, May 8, 1997, July 18, 1997, December 22, 1997, October 6, 1998, and June 1, 1999. *Id.*

Dr. Broudy examined Claimant on October 15, 1996. (DX 51, 74). Claimant presented the doctor with an approximately thirty year, one-half pack per day smoking history and a twenty-five year coal mine employment history. The doctor recorded Claimant's chief symptoms as shortness of breath, daily cough, sputum production, sleeping difficulties, and occasional foot and hand swelling. The doctor submitted Claimant to a pulmonary function test, arterial blood gas study, and a chest x-ray. Dr. Broudy recorded that Claimant's effort of the pulmonary function testing was "less than optimal," and that the results evidenced "only [a] slight abnormality with mild obstruction." *Id.* He opined that the abnormality may wholly be caused by poor patient effort. Dr. Broudy also reported that the arterial blood gas study results were normal, except for elevated carboxyhemoglobin due to cigarette smoking. Dr. Broudy interpreted the x-ray as negative for pneumoconiosis. In conclusion, the doctor diagnosed chronic bronchitis, and any concomitant obstruction, due to cigarette smoking, and he stated that Claimant retained the respiratory capacity to perform the work of an underground coal miner or similarly arduous manual labor.

Dr. Chaney issued a general letter opinion on May 23, 1997. (DX 58). Dr. Chaney opined that Claimant suffered from pneumoconiosis arising out of coal mine employment, and, because of the disease, he was disabled. The doctor provided no accompanying documentation or reasoning.

On June 9, 1998, Dr. Broudy examined Claimant again. (DX 74). He took Claimant's social, medical, and employment histories from him, noting Claimant's thirty year, half-pack per day smoking history and twenty-five year coal mining history. He noted that Claimant was retired and that he gardened and hunted to pass the time. Claimant's chief complaints included the following symptoms: shortness of breath, smothering when sleeping, cough, sputum production, wheezing, and swelling of the hands, feet, and ankles. Claimant also relayed to the doctor his occasional chest pain and dyspnea on exertion such as walking up hill for 300 to 400 yards. Dr. Broudy administered a physical examination, pulmonary function test, arterial blood gas study, and chest x-ray. He recorded that Claimant's pulmonary function test results were normal and the arterial blood gas study results demonstrated a mild resting arterial hypoxemia. Dr. Broudy interpreted Claimant's x-ray as negative for pneumoconiosis. The doctor assessed 1) patchy chronic interstitial pulmonary fibrosis, and 2) dyspnea with symptoms basically unchanged with 1996 examination.

Dr. Chaney examined Claimant on June 16, 1999. (DX 69). Claimant presented the doctor with a twenty year coal mine employment history, and Dr. Chaney included in his report that the claimant had not smoked in several years. The doctor performed the standard pulmonary examination. He opined that the chest x-ray was consistent with coal workers' pneumoconiosis and the pulmonary function test results evidenced a mild restriction. In conclusion, the doctor diagnosed coal workers' pneumoconiosis and stated that it would be best for Claimant to abstain from dust exposure.

Dr. Broudy examined Claimant on February 4, 2000. (DX 74). The doctor's examination was the fourth time he had examined the claimant. Dr. Broudy took Claimant's employment and social histories, noting an approximately thirty year, one-half pack of cigarettes per day smoking history and a twenty year coal mine employment history. During the examination, Claimant's chief complaints included the following symptoms: dyspnea upon exertion such as walking one-half mile or climbing one flight of stairs, daily cough, sputum production, ankle swelling, chest pain, night sweats, and trouble sleeping. In addition to his physical examination, which Dr. Broudy stated was unremarkable, the doctor administered a pulmonary function test, arterial blood gas study, and a chest x-ray. He also reviewed his findings of a previous examination of Claimant, an undated pulmonary function test, and a complete pulmonary work-up performed by Dr. Chaney. Dr. Broudy remarked that the pulmonary function test results demonstrated a mild restrictive defect, but they did not establish disability under the minimum federal criteria. The doctor found that the arterial blood gas study results were normal and the chest x-ray was negative for pneumoconiosis. Evaluating the additional evidence, Dr. Broudy found the undated pulmonary function test consistent with his own results, and he relayed that Dr. Chaney had interpreted another x-ray film as positive for pneumoconiosis. In conclusion, Dr. Broudy diagnosed patchy interstitial pulmonary fibrosis and chronic bronchitis. He stated that his chronic bronchitis diagnosis was based upon Claimant's history. Dr. Broudy specifically opined that Claimant did not suffer from pneumoconiosis, based upon his analysis of Claimant's pulmonary function test results and chest x-ray. The doctor stated that Claimant retained the pulmonary ability to perform underground coal mine work or similarly arduous labor.

On February 20, 2000, Dr. Chaney opined, in a general letter, that Claimant suffered from coal workers' pneumoconiosis. (DX 77). The doctor stated that a chest x-ray and pulmonary function test results he had reviewed were consistent with a diagnosis of pneumoconiosis.

Dr. Robert A. Wise issued an independent medical review on July 31, 2000. (DX 87). Dr. Wise reviewed 1) medical records, including pulmonary function tests, from the Lexington Clinic, 2) letters from Dr. Chaney, 3) medical records, including pulmonary function tests, from Dr. Dahhan, and 4) various x-ray films. Dr. Wise opined that Claimant did not suffer from pneumoconiosis. Furthermore, he concluded that Claimant possessed "no more than a slight impairment of pulmonary function." *Id.* Dr. Wise concluded that Claimant retained the residual functional respiratory capacity for heavy work activity.

E. Miscellaneous Medical Evidence

Various records from Appalachian Regional Healthcare are contained in the record. (DX 59). None of the records address Claimant's level of impairment or pneumoconiosis.

DISCUSSION AND APPLICABLE LAW

Because Claimant filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations, claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989).

Modification

Section 725.310 provides that a claimant, employer, or the district director may file a petition for modification within one year of the filing of the last denial of benefits. Modification petitions may be based upon a change in condition or a mistake in a determination of fact. 20 C.F.R. § 725.310(a). On May 15, 2001, Mr. Daniels timely requested modification of the denial dated September 15, 2000. (DX 89).

In the prior denial, the district director determined that claimant did not have pneumo-coniosis or any totally disabling respiratory or pulmonary disease arising from coal mine employment. The evidence submitted since this decision includes examination reports, independent medical review reports, chest x-rays, pulmonary function tests, and arterial blood gas studies. Therefore, I will consider whether this evidence, in conjunction with the previously submitted evidence, establishes entitlement to benefits.

A. *Mistake of Fact*

In deciding whether the prior decision contains a mistake in a determination of fact, I must review all the evidence of record, including evidence submitted since the most recent denial. New evidence, however, is not a prerequisite to modification based upon a mistake of fact. *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82, 1-84 (1993); *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156, 1-158(1990), *aff'd on recon.* 16 B.L.R. 1-71, 1-73 (1992). Rather, the factfinder is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971).

I have reviewed the previous denial, and I cannot locate any mistake of fact. Likewise, Claimant has made no attempt to allege a specific mistake of fact beyond Claimant's implied challenge to the Director's ultimate factual determination that Claimant is not entitled to benefits.

Accordingly, I shall proceed with my analysis to determine if the newly submitted evidence establishes a change in condition.

B. *Change in Conditions*

In deciding whether claimant has established a change in condition, I must "perform an independent assessment of the newly submitted evidence, in conjunction with evidence previously submitted, to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement." *Napier v. Director, OWCP*, 17 B.L.R. 1-111, 1-113 (1993). *See also Nataloni v. Director, OWCP*, 17 B.L.R. 1-82, 1-84 (1993). The circuit courts and Benefits Review Board have held that, for purposes of establishing modification, the phrase "change in conditions" refers to a change in the claimant's physical condition. *See General Dynamics Corp. v. Director, OWCP*, 673 F.2d 23 (1st Cir. 1982); *Director, OWCP v. Drummond Coal Co.*, 831 F.2d 240 (11th Cir. 1987); *Lukman v. Director, OWCP*, 11 B.L.R. 1-71 (1988) (*Lukman II*). *See, e.g., Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992) (letter from miner's physician indicating that the miner may have black lung disease did not establish a "change in conditions," but was sufficient to warrant reopening the claim based upon a "mistake in a determination of fact").

1. Review of the Newly Submitted Evidence

Pneumoconiosis and Causation

The new regulatory provisions at 20 C.F.R. § 718.201 contain a modified definition of "pneumoconiosis" and they provide the following:

(a) For the purposes of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis.

(1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (Dec. 20, 2000). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Each shall be addressed in turn.

Under section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

The newly submitted evidence contains six interpretations of five chest x-rays. Of these interpretations, two were negative for pneumoconiosis while four were positive for the disease.

The preponderance of the x-ray evidence is positive for pneumoconiosis. First, each "B" reader found his x-ray positive for pneumoconiosis. Furthermore, each "B" reader was also a board-certified radiologist. Likewise, the four most recent interpretations were all positive for pneumoconiosis. Thus, because the positive readings constitute the majority of interpretations, the most recent interpretations, and the interpretations produced by more, highly-qualified physicians, I find that the x-ray evidence is positive for pneumoconiosis.

The x-ray evidence clearly establishes pneumoconiosis. Because the previous denial found the evidence insufficient to establish pneumoconiosis, the newly submitted evidence clearly establishes a change in conditions. Further inquiry into the newly submitted evidence alone would be fruitless as Claimant has established his entitlement to a full review of the record. Accordingly, I shall examine all the medical evidence of record to determine if Claimant is eligible for benefits under the Act.

2. Review of the Entire Record

Pneumoconiosis and Causation

Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Each shall be addressed in turn.

Under section 718.202(a)(1), as noted above, a finding of pneumoconiosis may be based upon x-ray evidence. The record contains fifty-one interpretations of twenty chest x-rays. Of these interpretations, thirty-five were negative for pneumoconiosis while fifteen were positive. One x-ray was interpreted as unreadable. Of the interpretations produced by "B" readers, seven were positive and twenty-two were negative for pneumoconiosis. Of the interpretations produced by board-certified radiologists who were not "B" readers, one was positive for pneumoconiosis and none were negative. Of the interpretations produced by physicians who were both "B" readers and board-certified radiologists, six were positive and nineteen were negative.

On sheer numbers alone, the negative x-ray interpretations outweigh the positive interpretations. The issue of numerical superiority often arises with regard to evaluating medical evidence. The Board has held that an administrative law judge is not required to defer to the numerical superiority of medical evidence, *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990), although it is within his or her discretion to do so, *Edmiston v. F & R Coal Co.*, 14 B.L.R. 1-65 (1990). *See also Tokaricik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984) (the judge properly assigned greater weight to the positive x-ray evidence of record, notwithstanding the fact that the majority of x-ray interpretations in the record, including all of the B-reader reports, were negative for existence of the disease). I find the instant case is one predicted by *Tokaricik*. While the negative interpretations outnumber the positive x-ray interpretations, the weight of the evidence does not heavily favor one side. Five of the last six x-rays produced – June 16, 1999, February 3, 2000, February 4, 2000, June 5, 2000, September 15, 2001, and November 9, 2001 – yielded at least one positive interpretation. Four of the five positive interpretations were rendered by physicians who were either "B" readers or dually-qualified physicians.

The preponderance of the evidence shifts when I accord weight for recency. Because pneumoconiosis is a progressive and irreversible disease, it is appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). The Board has indicated that a seven month time period between x-ray studies is sufficient to apply the "later evidence" rule, but that five and one-half months is too short a time period. *Tokarcik, supra; Stanley v. Director, OWCP*, 7 B.L.R. 1-386 (1984). In the instant record, three x-ray interpretations were produced over one year later than the previously submitted interpretations. The three interpretations – produced by Drs. Baker, Barrett, and Alexander – are all positive for pneumoconiosis.

Thus, when I consider the relative equilibrium of the x-ray evidence, especially within the interpretations of those physicians with superior credentials, and the uniform positive interpretations of the most recent x-rays by three separate physicians, I find the preponderance of the x-ray evidence demonstrates that Claimant suffers from pneumoconiosis.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy or autopsy evidence. This section is inapplicable herein because the record contains no such evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions applies to this claim, claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides the fourth and final way for a claimant to prove that he has pneumoconiosis. Under section 718.202(a)(4), a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion may support the presence of the disease if it is supported by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 1-22, 1-24 (1986). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 B.L.R. 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms and patient's history. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Buffalo v. Director*, OWCP, 6 B.L.R. 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp*., 2 B.L.R. 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). *See also Phillips v.*

Director, OWCP, 768 F.2d 982 (8th Cir. 1985); *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.*, 4 B.L.R. 1-601 (1982).

The instant record contains approximately fifteen physician opinions addressing the presence or absence of pneumoconiosis. I shall evaluate and weight each opinion in chronological order.

Dr. Wicker's May 11, 1993 opinion concluding that Claimant does not suffer from pneumoconiosis is poorly reasoned. The doctor performed a complete pulmonary examination; however, Dr. Wicker provided no rationale for his diagnosis. He merely stated, "I see no evidence of pneumoconiosis." (DX 11). While the opinion is adequately documented, the complete absence of analysis renders the doctor's opinion less probative. Accordingly, I accord it less weight.

The July 1993 opinion of Dr. Wells bases its positive finding of pneumoconiosis solely upon Claimant's x-rays. No other rationale is provided. In *Cornett*, the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute "sound" medical judgment under section 718.202(a)(4). *Cornett*, 227 F.3d at 576. The Benefits Review Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(citing *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113(1989), and *Taylor*, 8 B.L.R. at 1-405). In *Taylor*, the Benefits Review Board explained that the fact that a miner worked for a certain period of time in the coal mines alone "does not tend to establish that he does not have any respiratory disease arising out of coal mine employment." *Taylor*, 8 B.L.R. at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray...and not a reasoned medical opinion." *Id.* Accordingly, I grant Dr. Wells's opinion less weight.

I accord Dr. Clarke's August 1993 opinion, diagnosing pneumoconiosis, probative weight. I find the doctor's opinion well reasoned and well documented. The doctor's report sufficiently catalogs his complete pulmonary evaluation, and the doctor's conclusions proceed reasonably from his reported medical information. Furthermore, the doctor sufficiently explains the rationale behind his positive diagnosis, as it is premised upon Claimant's x-rays, Claimant's dust exposure history, and the doctor's experience and examination observations.

I find Dr. Broudy's November 1993 opinion, as supplemented by his December 1993 deposition testimony, poorly reasoned. Dr. Broudy adequately documents his complete pulmonary evaluation; however, he fails to provide a rationale for his conclusion that Claimant does not suffer from pneumoconiosis. While the doctor explained that the arterial blood gas study and

pulmonary function test results indicated that Claimant's dyspnea was non-pulmonary in origin, he failed to present a rationale addressing the presence or absence of pneumoconiosis. Accordingly, I grant the doctor's opinion less weight.

Dr. Sundaram's March 1995 diagnosis of pneumoconiosis was based entirely on Claimant's x-rays and coal dust exposure history. Accordingly, I grant his opinion little weight due to inadequate bases under section 718. 202(a)(4). *See Cornett*, 227 F.3d at 576; *Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(citing *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113(1989), and *Taylor*, 8 B.L.R. at 1-405).

I accord Dr. Chaney's January 24, 1996 CT scan no weight as it is silent on the presence or absence of pneumoconiosis. Likewise, I grant no weight to the November 2, 1995, January 22, 1996, February 6, 1996, October 10, 1996, December 28, 1996, May 8, 1997, July 18, 1997, December 22, 1997, October 6, 1998, and June 1, 1999 opinions of Dr. Chaney. Each is silent as to the presence or absence of pneumoconiosis.

I find Dr. Broudy's October 1996 opinion poorly reasoned. While the doctor adequately documents his complete pulmonary evaluation, he provides no rationale for his diagnosis that Claimant does not suffer from pneumoconiosis. The doctor's only indication of the bases of his opinion is his discussion of Claimant's x-rays. X-ray interpretations alone, however, do not provide sufficient basis for a sound medical judgment. *See Cornett*, 227 F.3d at 576; *Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(citing *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113(1989), and *Taylor*, 8 B.L.R. at 1-405). Accordingly, I grant the doctor's opinion less weight.

In his opinion, Dr. Broudy also diagnosed chronic bronchitis. Again, however, the doctor failed to provide a rationale for his diagnosis. Accordingly, I grant his opinion less weight.

In his May 1997 letter diagnosing pneumoconiosis, Dr. Chaney provides no documentation and no rationale for his diagnosis. Thus, it is poorly reasoned and poorly documented, and I grant it little weight.

In his June 1998 opinion, Dr. Broudy diagnosed patchy chronic interstitial pulmonary fibrosis, but he opined that Claimant did not suffer from pneumoconiosis or silicosis. The lone section in which the doctor discusses his diagnosis of pneumoconiosis is contained within his discussion of Claimant's x-ray. Thus, I find the only basis for the doctor's opinion is Claimant's x-rays. X-ray interpretations alone, however, do not provide a sufficient basis for a sound medical judgment. *See Cornett*, 227 F.3d at 576; *Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(citing *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113(1989), and *Taylor*, 8 B.L.R. at 1-405). Accordingly, I grant the doctor's opinion no weight.

I grant Dr. Chaney's June 1999 opinion less weight because he fails to adequately document and provide reasons for his opinion. No basis is provided for his conclusions, and, furthermore, the only information contained within the doctor's report supporting his diagnosis of pneumoconiosis is the doctor's positive x-ray interpretations. X-ray interpretations do not provide sufficient basis for a sound medical judgment. *See Cornett*, 227 F.3d at 576. As I find his opinion poorly reasoned, I grant the doctor's opinion little weight.

I find Dr. Broudy's February 2000 opinion well reasoned and well documented. The doctor adequately documents his complete pulmonary work-up and the additional evidence he reviewed. Furthermore, he reports his findings clearly, and his conclusions follow reasonably from his reported data. Dr. Broudy diagnosed patchy interstitial pulmonary fibrosis and chronic bronchitis. The doctor's bronchitis diagnosis was based on Claimant's history. The doctor opined that Claimant did not suffer from pneumoconiosis based upon Claimant's pulmonary function test results and x-ray films. Accordingly, I grant Dr. Broudy's opinion probative weight.

Dr. Chaney's February 2000 letter opinion is adequately reasoned, as he bases his diagnosis of pneumoconiosis on Claimant's chest x-rays and pulmonary function test results. I grant his opinion less weight, however, because data upon which he bases his opinion is undocumented.

In his June 2000 opinion, Dr. Chaney diagnoses coal workers' pneumoconiosis; however, I accord the inadequately documented opinion little weight. Dr. Chaney fails to provide any documentation for his opinion. Instead, the doctor merely asserts that he has reviewed medical evidence and finds it consistent with pneumoconiosis. Such a lack of specificity renders the doctor's opinion less probative, and, thus, I grant it less weight.

Dr. Wise's July 2000 opinion, concluding that Claimant does not suffer from pneumoconiosis, is adequately documented as it catalogs the various pieces of medical evidence reviewed. Dr. Wise fails, however, to provide a rationale for his ultimate diagnosis concerning pneumoconiosis. The doctor's failure to provide the court with insight into the production of his opinion renders his opinion less probative. Accordingly, I grant the doctor's opinion less weight.

Dr. Baker's September 2001 opinion addressing pneumoconiosis, conversely, is well reasoned and well documented. The doctor based his opinion on Claimant's x-ray, history of dust exposure, and the lack of other factors present during his examination. Dr. Baker's opinion is sufficiently documented, and his conclusions proceed reasonably from the documented information contained within his report. Accordingly, I grant the doctor's opinion, diagnosing pneumoconiosis, probative weight.

I grant no weight to Dr. Rosenberg's November 9, 2001 opinion because it does not address the presence or absence of pneumoconiosis.

I find Dr. Rosenberg's September 13, 2002 examination report and independent medical review well reasoned and well documented, however. The doctor meticulously records the large array of medical information he reviewed, and he also sufficiently documented his examination observations. His diagnosis of no pneumoconiosis is adequately supported by an explicit rationale, composed of the doctor's examination observations and his interpretation of the objective medical evidence. Furthermore, I find his conclusions proceed reasonably from the objective data contained within his report. Accordingly, I grant the doctor's opinion probative weight.

I grant Dr. Vuskovich's September 25, 2002 opinion, and its accompanying October 30, 2002 deposition, less weight. The doctor's opinion is sufficiently documented, cataloging the large amount of medical evidence he reviewed. Dr. Vuskovich's analysis, however, is inadequate. First, the doctor's opinion does not clearly provide the rationale for his negative diagnosis concerning pneumoconiosis. In his conclusions, he merely states that the x-ray evidence was negative for the disease. If his ultimate opinion concerning the presence of pneumoconiosis was solely based upon the x-ray evidence, his opinion is entitled to no weight under section 718.202 (a)(4). *See Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000); *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985). In his "Summary" section, the doctor states, "The most important consideration, however, was that over the years, the "bellows[,]" "conduit[,]" and "gas exchange" functions of his thorax and lungs remained essentially normal and stable." (EX 3). Assuming that Dr. Vuskovich is stating that his observation concerning Claimant's thorax and lungs is the most important consideration concerning the presence of pneumoconiosis, the report would provide two bases for the doctor's final opinion addressing pneumoconiosis: x-ray interpretations and examination observations. While such bases can constitute a well reasoned opinion, I find the length to which one must fill in the gaps of the doctor's opinion lessens the probative value of it. Accordingly, I grant the doctor's opinion less weight.

I grant no weight to Dr. Wiot's deposition testimony taken on November 7, 2002. The doctor's testimony is solely concerned with his x-ray interpretations. Dr. Wiot did not examine Claimant, nor did he review other medical records. Given that the doctor solely relies on x-ray interpretations, I grant his opinion testimony no weight under section 718.202(a)(4). *See Cornett*, 227 F.3d at 569.

I grant little weight to the documents received from Appalachian Regional Healthcare Hospital listing coal workers' pneumoconiosis and chronic obstructive pulmonary disease as problems. The reports contain no documentation for the diagnoses, and, furthermore, no rationale is provided. Accordingly, I grant the documents little weight.

When I consider the narrative medical reports as a whole, I find the evidence is in equipoise. Numerous reports support a positive finding of pneumoconiosis, while other, also numerous, reports support a negative finding of pneumoconiosis. Many of the reports suffer from analytical flaws, entitling the reports to less or little probative weight. When I compare the opinions receiving full probative value, I continue to find the evidence in equipoise. The weight I

accord to the positive findings of Dr. Baker (September 2001 report) and Dr. Clarke (August 1993 report) is counter-balanced by the weight I grant to the negative findings of Dr. Rosenberg (September 2002 report) and Dr. Broudy (February 2000 report). Furthermore, the credentials of the physicians fail to clarify which side the preponderance of the evidence rests upon. As it is Claimant's burden to demonstrate pneumoconiosis by a preponderance of the evidence, I find the claimant has failed to demonstrate pneumoconiosis under section 718.202(a)(4).

Drs. Broudy and Baker opined that Claimant suffers from chronic bronchitis. Dr. Broudy attributing the chronic bronchitis to cigarette smoking, and Dr. Baker intimated that the bronchitis was caused by coal dust inhalation and cigarette smoking. In *Hughes v. Clinchfield Coal Co.*, 21 B.L.R. 1-134, 1-139 (1999), the Board held that chronic bronchitis satisfies the regulatory definition of legal pneumoconiosis if it arises out of coal mine employment. I do not find that Claimant suffers from chronic bronchitis, however, given the failure of the numerous other physicians to diagnose it in their respective medical reports. Given the large number of examination reports, the reports of Drs. Broudy and Baker, although probative, do not constitute a preponderance of the evidence, even if probative.

Claimant has demonstrated pneumoconiosis by a preponderance of the evidence under section 718.202(a)(1). Once it is determined that the miner suffers (or suffered) from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a).

Because Mr. Daniels has established over ten years of coal mine employment, he is entitled to a rebuttable presumption that his pneumoconiosis arose from coal mine employment. *See* 20 C.F.R. § 718.203(b). This presumption may be rebutted by evidence demonstrating another cause for claimant's pneumoconiosis. Only Dr. Broudy, in his October 1996 report, opined that Claimant suffered from a pneumoconiosis arising from a source other than coal mine employment. Dr. Broudy stated that Claimant suffered from chronic bronchitis due to smoking. I granted the doctor's opinion little weight, however, due to his failure to provide a rationale for his opinion. In his February 2000 opinion, Dr. Broudy again opined that Claimant suffers from chronic bronchitis, but he failed to attribute any etiology to the condition. I find this limited amount of evidence of another source of Claimant's pulmonary problems does not rebut the presumption to which Claimant is entitled. Accordingly, I find that Claimant's pneumoconiosis arose from coal mine employment.

In sum, the evidence establishes that Claimant has pneumoconiosis and that his pneumoconiosis arose out of coal mine employment. In order to establish entitlement to benefits, however, the evidence also must establish that claimant is totally disabled due to pneumoconiosis.

Total Disability Due to Pneumoconiosis

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(1). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 B.L.R. 1-11, 1-15 (1991). Section 718.204 (b)(2) provides several criteria for establishing total disability. Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1987).

Under Sections 718.204(b)(2)(i) and (b)(2)(ii), total disability may be established with qualifying pulmonary function tests or arterial blood gas studies.[9]

In the pulmonary function studies of record, there is a discrepancy in the height attributed to the claimant. The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1- 221 (1983). *See also Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995). Claimant's height was reported to be either 67 inches or 68 inches. Accordingly, I shall use the a rough average of 67. 5 inches for Claimant's height.

All ventilatory studies of record, both pre-bronchodilator and post-bronchodilator, must be weighed. *Strako v. Ziegler Coal Co.*, 3 B.L.R. 1-136 (1981). To be qualifying, the FEV_1 as well as the MVV or FVC values must equal or fall below the applicable table values. *Tischler v. Director, OWCP*, 6 B.L.R. 1-1086 (1984). I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1- 154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). In assessing the reliability of a study, I may accord greater weight to the opinion of a physician who reviewed the tracings. *Street v. Consolidation Coal Co.*, 7 B.L.R. 1-65 (1984). Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). If a study is accompanied by three tracings, then I may presume that the study conforms unless the party challenging conformance submits a medical opinion in support thereof. *Inman v. Peabody Coal Co.*, 6 B.L.R. 1-1249 (1984). Also, little or no weight may be accorded to a ventilatory study where the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984); *Justice v. Jewell Ridge Coal Co.*, 3 B.L.R. 1-547 (1981).

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[9]A "qualifying" pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(b)(2)(i) and (ii). A "non-qualifying" test produces results that exceed the table values.

The pulmonary function tests conform to the applicable quality standards, with the exception of the May 11, 1993, November 30, 1993 and July 1, 1993 pulmonary function tests. Dr. Wicker and Dr. Broudy reported that Claimant's cooperation was poor on the May 11, 1993 and November 30, 1993 tests, respectively. Accordingly, I shall grant no weight to the results. In addition, the July 1, 1993 test was composed of only one trial, whereas the regulations require three. 20 C.F.R. §718.108(b). Dr. Younes confirms this deficiency in his validation report. (DX 49). Accordingly, I shall also not consider Claimant's July 1, 1993 pulmonary function test results.

None of the remaining pulmonary function tests produced qualifying results, and I accord each probative value.

All blood gas study evidence of record must be weighed. *Sturnick v. Consolidation Coal Co.*, 2 B.L.R. 1-972 (1980). This includes testing conducted before and after exercise. *Coen v. Director, OWCP*, 7 B.L.R. 1-30 (1984); *Lesser v. C.F. & I. Steel Corp.*, 3 B.L.R. 1-63 (1981). In order to render a blood gas study unreliable, the party must submit a medical opinion that a condition suffered by the miner, or circumstances surrounding the testing, affected the results of the study and, therefore, rendered it unreliable. *Vivian v. Director, OWCP*, 7 B.L.R. 1-360 (1984) (miner suffered from several blood diseases); *Cardwell v. Circle B Coal Co.*, 6 B.L.R. 1-788 (1984) (miner was intoxicated). Similarly, in *Big Horn Coal Co. v. Director, OWCP [Alley]*, 897 F.2d 1045 (10th Cir. 1990) and *Twin Pines Coal Co. v. U.S. DOL*, 854 F.2d 1212 (10th Cir. 1988), the court held that the administrative law judge must consider a physician's report which addresses the reliability and probative value of testing wherein he or she attributes qualifying results to non-respiratory factors such as age, altitude, or obesity.

The arterial blood gas study results did not produce qualifying values. I grant each study probative weight.

Section 718.204(b)(2)(iii) provides that a claimant may prove total disability through evidence establishing cor pulmonale with right-sided congestive heart failure. This section is inapplicable to this claim because the record contains no such evidence.

Where a claimant cannot establish total disability under subparagraphs (b)(2)(i), (ii), or (iii), Section 718.204(b)(2)(iv) provides another means to prove total disability. Under this section, total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work.

The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 B.L.R. 1-1291 (1984).

A report may be adequately documented if it is based on items such as a physical examination, symptoms and patient's history. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Buffalo v. Director,* OWCP, 6 B.L.R. 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp.*, 2 B.L.R. 1-130 (1979). A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields*, 10 B.L.R. at 1-19. An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(holding report is properly discredited where physician does not explain how underlying documentation supports diagnosis). The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc).

In assessing total disability under § 718.204(c)(4), the administrative law judge, as the fact-finder, is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Budash v. Bethlehem Mines Corp.*, 9 B.L.R. 1-48, 1-51 (holding medical report need only describe either severity of impairment or physical effects imposed by claimant's respiratory impairment sufficiently for administrative law judge to infer that claimant is totally disabled). Once it is demonstrated that the miner is unable to perform his or her usual coal mine work, a prima facie finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(c)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

The instant record contains numerous physician opinions addressing the level of Claimant's impairment. I shall discuss and weigh each opinion in chronological order.

I accord Dr. Wicker's May 1993 opinion no weight because the doctor failed to address Claimant's level of impairment.

In his July 1993 opinion, Dr. Wells opined that Claimant was totally disabled based upon Claimant's July 1, 1993 pulmonary function test results. No other basis for the doctor's opinion was provided. Because I have found the July 1, 1993 pulmonary function test nonconforming to the applicable quality standards, I find Dr. Wells's opinion – solely reliant on that test – to be less probative. *See Director, OWCP v. Rowe*, 710 F. 2d 251, 255 n. 6 (6th Cir. 1983). Accordingly, I grant his opinion less weight.

Dr. Clarke opined that Claimant was totally disabled in his August 1993 opinion. His opinion contains a lengthy, highly detailed discussion of the disabling effects of the multiple injuries the claimant has suffered over the years. I find his discussion concerning Claimant's level of impairment due to non-pulmonary injuries well reasoned and well documented. I grant his analysis less weight overall, however, because Dr. Clarke's opinion appears to automatically assume total disablement immediately upon the presence of pneumoconiosis. Such a rationale is contrary to the Act, and I accordingly grant the doctor's opinion less weight.

I find Dr. Broudy's November 1993 opinion and December 1993 deposition testimony addressing Claimant's impairment level to be well reasoned and well documented. The doctor clearly provides his bases for determining that Claimant is not totally disabled, which include Claimant's arterial blood gas study and pulmonary function test results. The fact that Claimant's pulmonary function test results were invalidated due to poor effort does not affect that substance of the doctor's opinion because, even though invalid due to poor effort, Claimant's test results were still above federal disability standards. *Baize v. Director, OWCP*, 6 B.L.R. 1-730 (1984); *Wike v. Bethlehem Mines Corp.*, 7 B.L.R. 1-593 (1984). Furthermore, the doctor's impairment analysis was predicated upon Claimant performing arduous manual labor. As I find that Dr. Broudy sufficiently analyses the tension between Claimant's pulmonary capabilities and the exertional requirements of his coal mine employment, I grant the doctor's opinion probative weight.

In his March 1995 opinion, Dr. Sundaram opined that Claimant was totally disabled based upon his examination observations of Claimant's shortness of breath and Claimant's pulmonary function test results. The doctor's opinion is well documented; however, I grant it less weight due to the doctor's failure to discuss the exertional requirements of Claimant's usual coal mine employment. The doctor's failure renders his opinion concerning Claimant's ability to perform it less probative, especially since Claimant's pulmonary function test results were above the federal guidelines for disability. While a physician is not required to comment on the exertional requirements of an coal miner's employment, his opinion is less probative if he does not explore the exertional requirements when he uses the claimant's employment as shorthand for his level of disability. Thus, when a doctor does not opine that a claimant has a "slight," "mild," "moderate," or "heavy" pulmonary impairment, but, rather simply states that he is unable to perform his usual coal mine employment, as Dr. Sundaram did, a physician must provide an analysis of the exertional requirements of Claimant's usual coal mine employment to render his opinion probative of a specific level of impairment. Without such analysis, it is impossible to ascertain the level of impairment the doctor ascribes to the claimant. Accordingly, the opinion is entitled to less weight, and I so weigh Dr. Sundaram's opinion.

I accord Dr. Chaney's January 24, 1996 CT scan and his November 2, 1995, January 22, 1996, February 6, 1996, October 10, 1996, December 28, 1996, May 8, 1997, July 18, 1997, December 22, 1997, October 6, 1998, and June 1, 1999 medical reports no weight as they do not address Claimant's impairment level.

Dr. Broudy's October 1996 opinion is well documented; however it is not sufficiently reasoned. Dr. Broudy includes a summary of his interpretations of the objective medical tests, but he offers no rationale for his conclusion that Claimant retains the pulmonary ability to perform his usual coal mine employment. One is left to infer the bases for the doctor's opinion. The analytical shortcomings of the doctor's analysis lead me to grant the opinion less weight.

In his May 1997 letter, Dr. Chaney opines that Claimant is totally disabled. I grant the doctor's opinion little weight, however, because he provides neither documentation nor a rationale for his opinion. Such omissions render his opinion of little probative value.

I grant no weight to Dr. Broudy's June 1998 opinion. In the opinion, Dr. Broudy does not proffer an opinion on Claimant's impairment level.

I grant no weight to Dr. Chaney's June 1999 opinion. Dr. Chaney administered a standard pulmonary examination, and he concluded that it "would be best for [Claimant] to abstain from any dust exposure." (DX 69). The doctor provided no rationale for this opinion, beyond possibly inferential bases for his diagnosis of pneumoconiosis. Furthermore, the doctor's warning for Claimant to avoid further dust exposure is not tantamount to an opinion regarding Claimant's pulmonary ability to perform his usual coal mine employment or comparable work in a dust-free environment. Functionally, Dr. Chaney failed to address Claimant's impairment level in his opinion, and I grant it no weight.

Dr. Broudy's February 2000 opinion is well documented; however, I grant it less weight because it is not sufficiently reasoned. Like his October 1996 opinion, Dr. Broudy includes a summary of his interpretations of the objective medical tests, but he offers no rationale for his conclusion that Claimant retains the pulmonary ability to perform his usual coal mine employment. One is left to infer the bases for the doctor's opinion. As stated above, an unsupported medical conclusion is not a reasoned diagnosis. *See Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (finding report properly discredited where physician does not explain how underlying documentation supports diagnosis).

I accord Dr. Chaney's February 2000 and June 2000 opinion no weight because he fails to address Claimant's impairment level.

Dr. Wise's July 2000 opinion is well documented, and he explicitly bases his opinion that Claimant is not totally disabled by his slight impairment on Claimant's lung function as revealed in the records he reviewed. I grant the doctor's opinion probative weight.

In his September 2001 opinion, Dr. Baker opined that Claimant was totally disabled from his usual coal mine employment. The lone basis for the doctor's opinion was Claimant's pneumoconiosis. I find such a rationale insufficient. The Act and its attendant regulations require an individual to both 1) suffer from pneumoconiosis and 2) be totally disabled. The doctor's approach yields a totally disabled individual whenever pneumoconiosis is located. Such a rationale is inadequate under the Act, and I accord the doctor's opinion less weight.

I accord no weight to Dr. Rosenberg's November 2001 opinion because it fails to address Claimant's level of impairment.

I grant no weight to Dr. Mettu's narrative attached to Claimant's November 9, 2001 pulmonary function test results because, despite opining that Claimant suffers from a moderate obstructive airways disease, the doctor does not opine as to the level of Claimant's impairment.

I find Dr. Rosenberg's September 2002 opinion well reasoned and well documented. The doctor adequately demonstrates an understanding of the exertional requirements of Claimant's usual coal mine employment and he sufficiently records the pulmonary capabilities of the claimant. Dr. Rosenberg clearly presents the reasons behind his opinion that Claimant was not totally disabled, and his medical data is well documented. Accordingly, I grant the doctor's opinion probative weight.

I find Dr. Vuskovich's September 2002 opinion and October 2002 deposition testimony – addressing Claimant's impairment level and concluding that he is not totally disabled – well reasoned and well documented. Dr. Vuskovich adequately cataloged the medical evidence he reviewed, and his analysis proceeds reasonably from the information before him. He reaches clear conclusions, and his rationale is explicit and reasonable. Accordingly, I grant the doctor's opinion probative weight.

I grant no weight to Dr. Wiot's November 2002 deposition as he fails to address Claimant's impairment level.

When I consider all of the narrative evidence addressing Claimant's impairment level together, I find the preponderance of the evidence does not support a finding of total disability. No opinion concluding that Claimant is totally disabled received full probative value, whereas several opinions reaching the opposite conclusion did. I find the probative value I accord to the opinions of Drs. Rosenberg, Vuskovich, Broudy, and Wise outweighs the probative value of the opinions of Drs. Baker, Wells, Clarke, Sundaram, and Chaney.[10]

The preponderance of all of the evidence addressing Claimant's impairment level weighs heavily against the claimant. Jointly and individually, the pulmonary function tests, arterial blood gas studies, and narrative opinions weigh against the claimant. Accordingly, I find Claimant has not established total disability.

Conclusion

In sum, the evidence establishes the existence of pneumoconiosis and, concomitantly, a change in conditions, but it does not establish the existence of a totally disabling respiratory impairment. Accordingly, the claim of Conley Daniels must be denied.

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[10] I note that not all of the opinions of Drs. Rosenberg and Broudy received persuasive probative weight. Particularly persuasive, however, were Dr. Rosenberg's September 2002 opinion and Dr. Broudy's October 1993 opinion.

Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to claimant for legal services rendered in pursuit of the claim.

ORDER

The claim of Conley Daniels for benefits under the Act is denied.

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JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty days from the date of this decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington D.C. 20013-7601. This decision shall be final thirty days after the filing of this decision with the district director unless appeal proceedings are instituted. 20 C.F.R. § 725.479. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.